STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	07/29/2013

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 22, 23, 24, 25, 26, & 29, 2013 Facility number: 000389 Provider number: 15E245 AIM number: 100288920 Survey team: Gloria Bond, RN, TC Janet Stanton, RN Michelle Hosteter, RN Census bed type: NF 37 Residential 24 Total 61 Census payor type: Medicaid 35 Private 26 Total 61 Residential Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on August 2, 2013.	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop care plans related to behaviors, or use of a mood stabilizer medication and side effects for 2 of 22 residents reviewed for care plans. (Resident # 1 and Resident #23) Findings include: 1. The record review for Resident #23 was completed on 7/24/13 at 10 A.M. Diagnoses included, but were not limited to, high blood pressure, hypothyroidism, congenital heart	F000279	For resident #23 a Depakote level was drawn on 7-26-2013 which showed the level to be low. The physician is keeping the resident on the same dose of Depakote and the use of this drug will be noted in the Comprehensive care plan as well as the behavior care plan. Resident #1 now has routine blood work ordered and the nurses are instructed to chart her behaviors especially when she is having anxiety attacks. The guidelines given at the nurses meeting in regards to behavior will be followed. Once a month the Behavior management committee will meet with the	08/27/2013

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	anomaly, and senile dementia. The physician's orders for July 2013 indicated the resident was on Depakote (an antiseizure/mood stabilizer medication) 125 milligrams twice a day since 8/13/12. The care plan entires addressed issues that included, but were not limited to : short term memory, aspirin use and potential bleeding, and wandering. An entry addressing Depakote was not found. In an interview with the Director of Nursing on 7/26/13 at 9 A.M., she indicated that she had provided all of the care plans for Resident #23. There was no care plan for Depakote and reason for it being given and the side effects related to the medication. 3.1-35(a)		Psychiatrist and discuss the residents that are being seen that day as well as any resident who is currently showing behavioral changes. The Social worker will head the committee and the DON, ADON, MDS co-ordinator, Sister on the unit, a nurse on the unit, a CNA from the unit as well as family member if they so desire will be members of this committee. The Social worker will make note of behaviors since the last time the resident saw the psychiatrist. A copy of the Behavior Management Policy will be faxed to you. During the care conference there will be a review of the care plan to be sure that medications that need to be monitored are noted and reviewed for a gradual dose reduction The medical record consultant will be here monthly for the next three months and will check to be sure that the care plans are meeting all federal and state regulations. She will give us her findings in her exit meeting as well as her written report. Her first monthly visit was 8-22-2013 and the next visit will be 9-19-2013, at that time she will give us the date for October. She will check those care plans that were done between her visits. After the three months she will make regular random checks on her quarterly visits. Also all residents will have routine blood work ordered according to the medications being used. This	

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	2. The record for Resident #1 was reviewed on 7/24/13 at 1:36 P.M. Diagnoses included, but were not limited to, uncomplicated senile dementia, insomnia, and anxiety state. An initial psychiatric evaluation, completed on 7/6/12, indicated the resident had a diagnosis of depression and dementia with behavior disturbance. A description of how the behavior disturbance was displayed, the extent and severity of the disturbance, or other signs and symptoms to identify the behavior disturbance, was not found. An annual MDS (Minimum Date Set) assessment, dated 5/29/13, indicated the resident had no psychosis, but had "Other behavioral symptoms not		was reviewed at the nurses meeting as well as new guidelines went out to the nurses assuring that care plans would address any medication that needs montoiring. The QAA committee meeting is the 29th of August and this will be brought before the committee. The nursing compotet has revised policies to assure that this does not reoccur. The Behavior Committee will also be reviewing this as the address the resident's behavior.	

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	directed toward others" that occurred on 1 to 3 days in the previous 7-day assessment period. These behavioral symptoms had "No impact on resident or others." The resident was identified as not rejecting care, or wandering. The July, 2013 physician order recap (recapitulation) sheet included the following medications and original prescription dates: 6/19/12- -Quetiapine (Seroquel) 50 mg (milligrams) 1 by mouth every night at bedtime A Care Plan addressing the specific behaviors that required the use of an anti-psychotic medication was not found. In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated she believed the behaviors had been addressed, but would have to review the Care Plan. On 7/29/13 at 9:00 A.M., the Assistant Director of Nursing provided a copy of the resident's current care plan, with a note that indicated a "Care Plan for Seroquel had been present since 6/28/12--see page #7." The entry on page #7 of the Care			

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	Plan addressed "Resident is at risk for adverse side effects of antipsychotic medication." All of the interventions found in the care plan related to evaluating the resident for adverse side effects of the medication. There were no entries addressing the specific behaviors displayed by the resident that required the use of an anti-psychotic medication, or how to intervene or approach the resident when such behaviors were displayed. 3.1-35(b)(1)			

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F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview and record review, the facility failed to ensure a specific diagnosis was given, a specific behavior was identified, and/or behaviors were adequately monitored and quantitatively tracked to support the use of psychotropic medications. The facility failed to attempt a GDR (Gradual Dose Reduction) for psychotropic medications, or provide specific resident information related to any clinical contraindication to a dose	F000329	For resident #1 the nurses will follow the guidelines concerning charting for behaviors. These guidelines are that when a behavior occurs the charting will be done under the behavior charting and the charting should continue every shift for one week. This goes also for a gradual dose reduction. The behavior committee will meet prior to the psychiatrist monthly visit in the morning and then in the afternoon with the psychiatrist. The social worker will head the committee and will	08/28/2013

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	reduction. Further, the facility failed to ensure non-psychotropic medications were adequately monitored through laboratory blood tests. This deficient practice affected 7 of 10 residents reviewed for Unnecessary Medication Use. (Residents #1, #3, #9, #15, #19, #23, and #32) Findings include: 1. The clinical record for Resident #1 was reviewed on 7/24/13 at 1:36 P.M. Diagnoses included, but were not limited to, uncomplicated senile dementia, hypertension, emphysema, chronic obstructive pulmonary disease, insomnia, anxiety state, and lumbago. An initial psychiatric evaluation, completed on 7/6/12, indicated the resident had a diagnosis of depression and dementia with behavior disturbance. A description of how the behavior disturbance was displayed, the extent and severity of the disturbance, or other signs and symptoms to identify the behavior disturbance, was not found. An annual MDS (Minimum Date Set) assessment, dated 5/29/13, indicated the resident had no psychosis, but had "Other behavioral symptoms not directed toward others" that occurred		maintain a separate care plan book for behaviors. The behaviors will also be noted on the comprehensive care plan. The ADON will maintain a grid that will help in following the resident's progress. The medical record consultant will review these when she visits to assure that the notes are being done and communication is being given to the psychiatrist. If a behavior does not occur every shift a health status note will be written linking it the behavior notes. Resident #15 Medical Doctor reduced the Lexapro and in a month's time will discontinue. Resident #19 expired on July 27th, 2013. Resident #32 had her Remeron discontinued because of adverse reaction making her very hyper. Resident requested that it be started because it helped her appetite. Resident #3 her Celexa was lower to 20mg instead instead of 30mg. Resident #9 was seen by the Psychiatrist and her Seroquel was reduce to 50mg t.i.d instead of 50mg q.am and at noon and a 100mg at night. The ADON reviewed all of the Behavior notes and has made a grid to follow all GDR as well as noting if the Behavior increased with the GDR. The Behavior Committee will also address this issue. The Behavior Committee Policy is being forwarded to you. as well as the Behavior log. When the Social Worker does her Behavior	

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	on 1 to 3 days in the previous 7-day assessment period. These behavioral symptoms had "No impact on resident or others." The resident was identified as not rejecting care, or wandering. The July, 2013 physician order recap (recapitulation) sheet included the following medications and original prescription dates: 9/25/12--Fluoxetine (Prozac) 40 mg. (milligrams) 1 by mouth twice a day 6/19/12--Quetiapine (Seroquel) 50 mg. 1 by mouth every night at bedtime 9/27/12--Furosemide 40 mg. 1 by mouth twice a day A. An initial consultant psychiatric evaluation on 7/6/12 indicated the resident was admitted on Prozac (an anti-depressant medication) at a dose of 20 mg. (milligrams) daily. On that date, following the evaluation, the dose was increased to 30 mg. daily because the resident reported to the psychiatrist that "she feels depressed and anxious at times." A psychiatric follow-up visit was done on 9/25/12. The report indicated "Pt. (patient) seen today. Staff reported Pt. has been depressed, having		Care Plan she will also insert it into the Comprehensive Care plan. The Medical Record Consultant will reviewed the records of those having behaviors or a GDR. montly times three. Her first visit was on August 22, 2013, Her next visit will be September 19th, 2013 and at that time she will notified us of the date of her visit for October. After this she will review random records on her quarterly visits. The QAA committee meets on August29th, 2013 this will be reviewed with the committee and a proposal made to see if it is practical to have the family sign a consent sheet when their loved one has a mind altering drug ordered. Our Psychiatrist is eeing with the company she works for if she caqn change the existing form to have more detail as to why or why not a drug needs to reduced.	

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	Medicaid issues. Pt. says she admitted being depressed at times ...Pt. says she is doing O.K. for her age. No problems. Mildly depressed. Increase Prozac to 40 mg. per day." Documentation related to an escalation in depressive symptoms that warranted an increase in the anti-depressant medication was not found. Follow-up consultant psychiatric progress notes indicated the following: 12/27/12--"...Staff reported Pt. was sleeping too much ...Pt. denied being depressed. Denied having problem with sleep and appetite ...." 3/19/13--"Nursing reported no issues ...Pt. denied being depressed. Denied being anxious. No problem with sleep and appetite ...." 5/21/13--"Pt. says she is doing fine. Nursing reported no issues. No problems with sleep and appetite ...." Each of the follow-up reports had a section for the consultant psychiatrist to indicate "Plan: Psychotropic Medications Reviewed." At each of the visits, the consultant had circled and underlined a pre-printed statement that indicated a dose			

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	reduction "Is Not indicated at this time. Reason: Risk of relapse is to [sic] great, current benefits of treatment outweigh risks at this time." There was no other specific resident information to explain what information this decision was based on, or how this decision was otherwise determined. B. A diagnosis to support the use of Quetiapine (Seroquel--an antipsychotic medication), which was ordered on 6/19/12, was not found. A PASRR/MI (Preadmission Screening Resident Review/Mental Illness) Level II assessment was completed on 1/2/13. The report indicated "NF [nursing facility] staff report [resident's name] is generally pleasant. She exhibits behaviors with making odd comments at times. She presents with no other behavioral problems ...Diagnoses--Major depression, anxiety, senile dementia. History of anxiety most of her life. No history of inpatient [hospital] treatment ...Needs Further Review: Reconsider Clonazepam and Quetiapine with cognitive dysfunction; Fall risk and cognitive problems with both; consider reduction trial." "Psychoactive Medication Evaluation"			

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	forms, completed by the facility, indicated the following: 3/5/13-- Drug--Seroquel, Klonopin, Prozac. Diagnoses--Dementia with behavior disturbances, anxiety; insomnia. Behaviors/symptoms warranting use of medication--Depression, anxiety, insomnia, will constantly pic ...." Episodes of behavior per week--1 (There was no documentation related to the type of behavior.) Last dosage reduction--12/27/12 (This dose reduction was for the Klonopin only. None of the other medications were considered for GDR) 5/28/13-- Drug--Seroquel, Klonopin, Prozac. Diagnoses--Dementia with behavior disturbances, anxiety, insomnia. Behaviors/symptoms warranting use of medication--sadness, anxiety. (The sections for last dose reduction or psychiatric services was blank) Social Service progress notes indicated the following: 3/6/13--"Followed by Dr. [psychiatrist's name]; her Klonopin dosage was reduced on 12/27/12 due to excessive somnolence. PRN [as needed] order for Lorazepam was discontinued 12/28/12 due to			

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	non-use." 5/29/13--"...continues to be followed by Dr. [psychiatrist's name] for psychotropic medication management; last seen on 5/20/13. Nursing notes indicate no mood or behavioral changes." Documentation related to type of behavior(s), the extent, severity, or quantitative number of episodes, to support the use of the anti-psychotic medication was not found. In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated the facility used to keep a paper log for monitoring behaviors. After switching to an electronic health record system for some of their documentation, behaviors were documented in the nursing progress notes. She indicated she read through the notes, but did not track or summarize the types of behaviors displayed. She was not sure who might be responsible for that process, and the facility did not have a program for behavior management. She indicated she had been working with the psychiatrist on GDRs for some residents, but this resident was not one of them.			

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	C. On 9/27/12, the physician gave an order for Furosemide (Lasix--a diuretic used for edema associated with congestive heart failure or hypertension) 40 mg. one by mouth twice a day, for a total daily dose of 80 mg. The "Drug Information Handbook for Nursing," 8th Edition, 2007 indicated people who received this medication should be monitored for renal function and electrolyte disturbances, including periodic routine BUN (Blood Urea Nitrogen), Creatinine, and electrolyte laboratory blood tests. An order for routine laboratory blood tests to check kidney function or electrolytes was not found. A BMP (Basic Metabolic Panel) was done 1/19/13. In an interview on 7/25/13 at 9:17 A.M., R.N. #3 indicated she would have to look at the resident's orders (to check for labs to monitor for Lasix). She indicated the Director of Nursing and Assistant Director of Nursing would know more about that, since "they handle labs." In an interview on 7/25/13 at 10:55			

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	A.M., the Director of Nursing indicated routine lab orders sometimes do not come through on the re-writes, and she would have to review the chart. In an interview on 7/25/13 at 12:30 P.M., the Director of Nursing indicated she had reviewed the resident's record back to admission date. The resident never had a routinely scheduled lab to monitor for the Lasix. The test done in January, 2013 was in response to a change in the Klonopin dosage. 2. The record for Resident #9 was reviewed 7/24/13 at 10:14 A.M. Diagnoses included, but were not limited to, depressive disorder, hypertension, macular degeneration, dysphagia, persistent mental disorder, and dementia with behavior disturbance. A description of how the behavior disturbance was displayed, the extent and severity of the disturbance, or other signs and symptoms to identify the behavior disturbance, was not found. A quarterly MDS (Minimum Data Set) assessment, dated 6/19/13, indicated the resident had no psychosis, no behaviors, no resistance to care, and no wandering.			

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	15E245	A. BUILDING 00 B. WING	07/29/2013

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The July, 2013 physician order recap (recapitulation) sheet included orders for the following medications:
11/9/05--Fluoxetine (Prozac--an antidepressant medication) 10 mg. (milligrams) one capsule by mouth daily.
12/29/09--Quetiapine (Seroquel--an anti-psychotic medication) 100 mg. one by mouth every evening (scheduled for 8:00 P.M.)
5/18/12--Quetiapine (Seroquel) 50 mg. one by mouth twice a day at 10 A.M. and 2 P.M.

A. On 11/9/05, Fluoxetine (Prozac--an antidepressant medication) 10 mg. (milligrams) one capsule by mouth daily was ordered by the physician.

Documentation related to the extent, severity, or monitoring and quantitatively tracking the number of episodes of depressive symptoms was not found. A GDR (Gradual Dose Reduction) attempt, or specific resident information related to the reason it was clinically contraindicated, was not found.

A consultant psychiatrist progress report, dated 5/16/12, listed the Prozac and dosage, but had no other

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	documentation addressing extent and severity of the depressive symptoms. The report indicated "Nursing reported Pt. [patient] continues to be having inappropriate verbalizations. Pt. says she is doing fine, but inappropriate in making statements and answering questions. No problem with sleep or appetite." In the section for "Plan: Psychotropic Medications Reviewed. Dosage Reduction ...," the psychiatrist had circled and underlined a pre-printed statement of "[GDR] Is Not indicated at this time. Reason: Risk of relapse is to [sic] great, current benefits of treatment outweigh the risks at this time." There was no other specific resident information to indicate which medication this statement referred to, to explain what information this decision was based on, or how this decision was otherwise determined. Follow-up consultant psychiatrist progress notes, dated 11/29/12 and 5/21/13 listed the Prozac medication, and indicated the resident denied being depressed, was doing O.K., had no problems with sleep or appetite, or was having any behavior issues. Each progress note indicated a GDR was not indicated for the same reasons listed on the 5/16/12 note. There was no other specific			

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	resident information to indicate which medication this statement referred to, to explain what information this decision was based on, or how this decision was otherwise determined. B. On 12/29/09, Quetiapine (Seroquel--an anti-psychotic medication) 100 mg. one by mouth every evening (scheduled for 8:00 P.M.) was ordered. On 5/18/12--Quetiapine (Seroquel) 50 mg. one by mouth twice a day at 10 A.M. and 2 P.M. was ordered. The resident had a diagnosis of dementia with behavior disturbance. A specific description of how the behavior disturbance was displayed, the extent and severity of the disturbance, or other signs and symptoms to identify the behavior disturbance, was not found. Documentation related to type of behavior(s), the extent, severity, or quantitative number of episodes, to support the use of the anti-psychotic medication was not found. A pharmacy consultant "Note to Attending Physician/Prescriber" form, dated 11/13/12 requested an evaluation of the current dose of Seroquel, and to consider a gradual taper. The physician was requested			

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	to "Please check the appropriate response and add additional information as requested." Five pre-printed options were provided on the form. The physician responding checked the option which stated "Condition is not well controlled/stable and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information)." Additional resident specific information was not documented. "Psychoactive Medication Evaluation" forms, completed by the facility, indicated the following: 3/20/13-- Drug: Fluoxetine, Seroquel Diagnosis warranting use: Depression, Dementia with Behavior Disturbance Behaviors/Symptoms warranting use of medication: "Sadness; inappropriate verbalizations, resistant w ...." Episodes of behavior per week: 1 6/13/13- Drug: Fluoxetine, Seroquel Diagnosis warranting use: Depression, Dementia with Behavior Disturbance Behaviors/symptoms warranting use of medication: Sadness, inappropriate			

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	verbiage Episodes per week: 1 Comment: "Resident will call out to other residents telling them they are ugly, and or stupid. She might call them names." There were no dates listed for last dose reduction; and no other information related extent, severity, of actual number of episodes of specific behaviors displayed. A Nursing Summary, dated 6/20/13, indicated "No behaviors present; Behavioral symptoms: none exhibited." Social Service progress notes indicated: 12/20/13: "no behavioral changes...." 3/20/13: "Nursing notes do not indicate any mood or behavioral disturbances during assessment period ...." 6/19/13: (no info about behaviors); 6/25/13: "Mood and demeanor fluctuate, she can be redirected ...." On 7/24/13 9:36 A.M., the resident was observed sitting in the hallway across from NS the (nursing station), with another resident next to her. She was smiling and pleasant. At 9:45 A.M., the nurse was adjusting			

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	the resident's leg wraps while she was sitting in the lounge area. The resident was observed to sit quietly, conversing softly and pleasantly with the nurse. Documentation related to type of behavior(s), the extent, severity, or quantitative number of episodes, to support the use of the anti-psychotic medication was not found. In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated the facility used to keep a paper log for monitoring behaviors. After switching to an electronic health record system for some of their documentation, behaviors were documented in the nursing progress notes. She indicated she read through the notes, but did not track or summarize the types of behaviors displayed. She was not sure who might be responsible for that process, and the facility did not have a program for behavior management. She indicated she had been working with the psychiatrist on GDRs for some residents, but this resident was not one of them. 3. The clinical record for Resident #19 was reviewed on 7/25/13 at 1:02			

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	P.M. Diagnoses included, but were not limited to, SDAT (senile dementia--Alzheimer's type), and anxiety state. On 3/19/13, the consultant psychiatrist indicated the resident was paranoid; and on 6/21/13, added a diagnosis of dementia with delusions. The July, 2013 physician order recap (recapitulation) sheet included the following medications: 3/19/13--Quetiapine (Seroquel) 25 mg. (milligrams)--give two 1/2 tabs twice a day, total dose 25 mg.. 3/19/13--Quetiapine (Seroquel) 25 mg. half tab (12.5 mg.) by mouth daily PRN (as needed) The quarterly MDS (Minimum Data Set) assessment, dated 6/24/13, indicated the resident had no psychosis, no behavior, no rejection of care, and no wandering. "Psychoactive Medication Evaluation" forms completed by the facility indicated the following: 3/20/13-- Drug: Celexa, Seroquel Diagnosis warranting use: depression, SDAT with behavior disturbance. Behaviors/symptoms warranting use of medication: sadness, anxiety, looking for deceased wife. Episodes			

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	per week: 3 Comments: "continue behaviors; paranoia, thinking we are poisoning him with medications. Attempting to transfer and walk when resident is not able to. Has periods of anxiety and agitation." 6/13/13-- Drug: Celexa, Seroquel, Buspar Diagnosis warranting use: Depression, SDAT with behavior disturbances Behaviors/symptoms warranting use of medication: Sadness, delusions, anxiety Episodes of behavior per week--2 Social Service progress notes indicated the following: 1/8/13--" ...He was recently seen by (psychiatrist); the only medication change was to increase his Namenda to 2 times daily...." 3/20/13--"They [staff] indicated resident will at times recognize staff and family ... yells out throughout the day; but does not identify his agitation as pain. When he is given medication for pain he does become calm ...seen (by psychiatrist) on 3/19 and had a change in his Seroquel medication. Nursing notes indicate no mood or behavioral episodes during this assessment."			

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	3/26/13--"Attempted GDR 2/7/13 of Seroquel was not successful. He had become increasingly agitated, anxious, and restless." Documentation related to the specific types of behavior(s) displayed, the extent, severity, or quantitative number of episodes, to support the use of the anti-psychotic medication was not found. In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated the facility used to keep a paper log for monitoring behaviors. After switching to an electronic health record system for some of their documentation, behaviors were documented in the nursing progress notes. She indicated she read through the notes, but did not track or summarize the types of behaviors displayed. She was not sure who might be responsible for that process, and the facility did not have a program for behavior management. 4. The clinical record for Resident #15 was reviewed on 7/25/13 at 9:49 A.M. Diagnoses included, but were not limited to, cerebral vascular disease with hemiplegia non-dominant side, depressive			

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	disorder, and dementia without behavioral disturbance. On 4/26/07, the attending physician ordered Escitalopram (Lexapro--an antidepressant medication) 10 mg. (milligrams) one by mouth daily. The quarterly MDS (Minimum Data Set) assessment, dated 6/19/13, indicated the resident had no indicators of mood, no psychosis, and no behaviors. "Psychoactive Medication Evaluation" forms, completed by the facility, indicated the following: 3/20/13-- Drug: Lexapro Diagnosis warranting the use.: Depression Behavior/symptoms warranting use of medication: Sadness Episodes of behavior per week: 0 (There was no date listed for the last dosage reduction, if any had been attempted; or for any psychiatric services involved.) 6/13/13--The same information was recorded. There was no documentation of a recommendation or request for GDR attempt. Documentation related to type of			

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	behavior(s), the extent, severity, or quantitative number of episodes, to support the continued use of the anti-depressant medication was not found. In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated the facility used to keep a paper log for monitoring behaviors. After switching to an electronic health record system for some of their documentation, behaviors were documented in the nursing progress notes. She indicated she read through the notes, but did not track or summarize the types of behaviors displayed. She was not sure who might be responsible for that process, and the facility did not have a program for behavior management. She indicated she had been working with the psychiatrist on GDRs for some residents, but this resident was not one of them. 5. The record review for Resident #23 was completed on 7/24/13 at 10 A.M. Diagnoses included, but were not limited to, high blood pressure, hypothyroidism,, senile dementia, coronary bypass surgery,			

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	osteoporosis, and cardiac murmur. The resident was admitted 8/13/12. On 11/20/12, the psychiatric consultant added diagnosis of dementia with paranoia. The admission evaluation and interim care plan dated 8/13/12 had a section which listed medical history. The section indicated the resident had hypothyroidism, cardiovascular disease, dementia, and arthritis. There was a section available to write in other information and nothing was documented. The physician's orders for July 2013 indicated the resident was on Seroquel (an antipsychotic medication) 12.5 milligrams twice a day since 11/19/12 and Depakote (used for seizures and as a mood stabilizer medication) 125 milligrams twice a day since 8/13/12. There was no diagnosis for the use of the Depakote. The nurses notes indicated : 8/24/12- "...Resident states "someone is stealing my nylons. My daughter bought me six pair and if this is tolerated I'm getting the hell out of here. Nurse assured resident she could speak with staff about any problems she has on the unit			

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	Resident was satisfied with that information...." 9/19/12-"...Resident took rings off this morning and put them under pillow, told certified nursing aide her daughter had come to pick up rings...." 10/5/12-" ...Resident states "someone took my money and make-up. Resident was putting on her makeup while saying this. Staff has tried multiple times this morning to reorient without success...." 4/3/13- "...Resident was not able to locate her glasses from 3/29/13 until her family found then(sic) wrapped in shelf paper in one of her drawers yesterday, She daily takes glasses off and puts them in various drawers, shoes or anywhere else she can think of...." 4/29/13-"...Missing her wristwatch and she told me I could look in her room. Found it in the second drawer of her chest...." A psychoactive medication evaluation that the staff performed on 4/18/13, indicated the resident received Seroquel 12.5 milligrams twice daily for senile dementia with paranoia due to her thinking people are taking her things. The number of episodes of behaviors per week was 1. The psychoactive evaluation dated			

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	7/12/13, indicated the resident is getting Seroquel 12.5 milligrams twice daily due to paranoia of hiding things and then stated others took them. Episodes of behaviors per week 1. The psychiatric assessment dated 11/20/12 indicated, "...mood-'great'...illogical at times, no suicidal ideations, no auditory or visual hallucinations, and no homicidal ideations....dementia with paranoia...treatment plan- started on Seroquel 12.5 milligrams twice daily. Will monitor signs and symptoms and progress. Monitor document to follow episodes and behaviors...." The psychiatrists progress notes dated 12/27/12 indicated, "...staff reported no issues...assessment moderately better...psychotropic medications reviewed dosage reductions not indicated at this time...3/19/13-Nursing reported no issues...Assessment: stable...psychotropic medications reviewed dosage reductions not indicated at this time...." There was a note to the attending Prescriber dated 5/21/13 from the pharmacy that indicated, "....This resident has been on Seroquel 12.5 milligrams twice daily since 11/29/12.			

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	Please evaluate the current dose and consider a gradual taper to ensure the resident is using the lowest possible effective/optimal dose..." The physician marked an x by the box indicating, "Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweighs risks for this patient and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information):.." The physician checked a box marked "disagree" and wrote "Stable with current diagnosis." In an interview on 7/26/13 at 9:30 A.M., the Assistant Director of Nursing indicated the facility used to keep a paper log for monitoring behaviors. After switching to an electronic health record system for some of their documentation, behaviors were documented in the nursing progress notes, She indicated she read through the notes, but did not track or summarize the types of behaviors displayed. She was not sure who might be responsible for that process, and the facility did not have a program for behavior management. She indicated she had been working with the			

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	psychiatrist on GDR's for some residents, but this resident was not one of them. In an interview with the Director of Nursing on 7/25/13 at 1:15 P.M., she indicated she understood from the nursing facility in Evansville the resident received Depakote for mood stabilization. A request was made at this time for any documentation regarding diagnosis of mood disorder for Depakote medication, as well as regarding a dose reduction for Seroquel. As of exit conference on 7/29/13 at 2 P.M., no further information had been provided 6. The record for Resident #3 was reviewed at 11:30 A.M., on 7/24/2013. Diagnoses included, but were not limited to, depression, high blood pressure, Alzheimer's disease, esophagitis (inflammation of the esophagus), and degenerative arthritis. Resident #3's record indicated the following two medications classified as anti-depressants were being given by mouth: Celexa (citalopram) 30 mg daily since 2004 and Trazodone 25 mg at bed time since 4/11/2013. The Pharmacist medication regimen			

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	review dated 1/16/2013, indicated a recommendation to the Prescriber to reduce the dose of the antidepressant Celexa from 30 mg/day to 20 mg/day because of the PPI (Proton Pump Inhibitor)Nexium, the resident was receiving, may increase the serum concentration of the Celexa and increased the risk of toxicity. The Physician responded on 1/30/2013 and disagreed with the recommendation. There was no attempt of dose reduction found in the record for this medication. During an interview on 7/26/2013 at 9:30 A.M., the ADON indicated she provided information verbally to the Psychiatrist and followed the orders given. Clarification on the plan of care by the Psychiatrist or guidelines regarding behavior tracking and gradual dose reduction was not discussed with the Psychiatrist. 7. The record for Resident #32 was reviewed at 10:30 A.M., on 7/24/2013. Diagnoses included, but were not limited to, depressive disorder, congestive heart failure, insomnia, and atrial fibrillation. Resident #32's record indicated the following two medications classified as anti-depressants were being given by mouth: Celexa 30 mg daily since			

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	6/27/2012 and Remeron 15 mg at bedtime since 5/9/2013. The Pharmacist medication regimen review for Resident #32 dated 2/12/2013, recommended to the Prescriber a dose reduction on the anti-depressant Celexa to 20 mg per day. The Pharmacist indicated the maximum recommended dose for patients older than 60 years of age is 20 mg per day. The Psychiatrist responded on 5/9/2013 and disagreed with the recommendation. Resident #32's Psychiatric Progress note dated 5/21/2013, indicated Resident #32 had experienced hypomania secondary to the antidepressant and an anti-convulsant Depakote 125 mg twice per day was started. A Psychiatric progress note dated 6/18/2013, indicated Resident #32 was doing better but complaining of being tired most of the afternoon. The anti- depressant Celexa was increased to 40 mg per day. During an interview on 7/24/2013 at 12:45 P.M., with the Social Service Director, she indicated the DON (Director of Nursing) monitors the residents with behavior problems and			

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	is working on a better behavior monitoring documentation. The ADON(Assistant Director of Nursing) works with the Psychiatrist on the psychiatric medications being given. During an interview on 7/26/2013 at 9:30 A.M., the ADON indicated she provided information verbally to the Psychiatrist and followed the orders given. Clarification on the plan of care by the Psychiatrist or guidelines regarding behavior tracking and gradual dose reduction was not discussed with the Psychiatrist. 3.1- 48 (a) (1) 3.1- 48 (a) (2) 3.1- 48 (a) (3) 3.1- 48 (a) (4) I			

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F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on interview and record review, the facility failed to ensure the pharmacy consultant was reporting irregularities, related to recommendations for laboratory blood tests, for 2 of 10 residents reviewed for Unnecessary Medication Use. (Residents #1 and #23) Findings include: 1. The clinical record for Resident #1 was reviewed on 7/24/13 at 1:36 P.M. Diagnoses included, but were not limited to, uncomplicated senile dementia, hypertension, emphysema, chronic obstructive pulmonary disease, and anxiety state. On 9/27/12, the physician gave an order for Furosemide (Lasix--a diuretic used for edema associated with congestive heart failure or hypertension) 40 mg. one by mouth twice a day, for a total daily dose of 80 mg.	F000428	For resident #1 and #23 they had the appropriate blood work drawn. #23 the Depakote level was low and Doctor felt this is what it should be to control mood swings. A policy covering appropriate laboratory studies for medication was made and a copy is being faxed to you office. When we have a new admission this will be part of the protocol to assure that medication will be followed properly. This also goes for when a Doctor orders a new medication he will be requested to give us the frequency in which he wants the labs. done The ADON has reviewed all residents medical records and obtained orders for appropriate laboratory tests. She also obtained diagnosis for medications that were ordered. When the nurses do the the rewrites they will be sure that the lab orders are current. The head pharmacist, was notified of the need for the consultant to check for lab tests pertaining to medication. We have been informed that we will have a new consultant	08/28/2013

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	The "Drug Information Handbook for Nursing," 8th Edition, 2007 indicated people who received this medication should be monitored for renal function and electrolyte disturbances, including periodic routine BUN (Blood Urea Nitrogen), Creatinine, and electrolyte laboratory blood tests. An order for routine laboratory blood tests to check kidney function or electrolytes was not found. Documentation indicated a consultant pharmacist had reviewed the resident's clinical record on a monthly basis. Recommendations from the pharmacist to have a routine laboratory test done was not found. A BMP (Basic Metabolic Panel) was done 1/19/13. In an interview on 7/25/13 at 9:17 A.M., R.N. #3 indicated she would have to look at the resident's orders (to check for labs to monitor for Lasix). She indicated the Director of Nursing and Assistant Director of Nursing would know more about that, since "they handle labs." In an interview on 7/25/13 at 10:55 A.M., the Director of Nursing		pharmacist as of August 28th, 2013. When the nurses do the rewrites they have a protocol sheet to follow to assure that needed labs are ordered. The medical department will check the records for labs that are needed monthly for three months and they will keep an audit book reflecting this. The protocol sheet will be faxed to you. At the nurses meeting on August 13th, 2013 this [protocol was reviewed with all the nurses and for those unable to atttend a type copy of the notes was given to them. Also a copy of the notes will be faxed to your office.This will be brought up at the QAA meeting on August 29th, 2013 to get their approval or any corrections that they feel is needed in the policy.	

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	indicated routine lab orders sometimes do not come through on the re-writes, and she would have to review the chart. In an interview on 7/25/13 at 12:30 P.M., the Director of Nursing indicated she had reviewed the resident's record back to admission date. The resident never had a routinely scheduled lab to monitor for the Lasix. The test done in January, 2013 was in response to a change in the Klonopin dosage. She had no idea why the pharmacy consultant had not requested or recommended the facility obtain a physician order for a routine laboratory order. 2. The record review for Resident #23 was completed on 7/24/13 at 10 A.M. Diagnoses included, but were not limited to, high blood pressure, hypothyroidism, congenital heart anomaly, senile dementia, hyperlipidemia, Coronary bypass surgery, venous deficiency, osteoporosis, and cardiac murmur. The physician's orders for July 2013 indicated the resident had an order for Depakote (used for seizures and as a mood stabilizer medication) 125 milligrams twice a day since 8/13/12.			

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The labs were reviewed from 8/13/12 through 7/25/13. There were no Depakote (Valproic Acid) levels done.

In an interview with LPN #1 on 7/25/13 at 9:45 A.M., she indicated the recapitulation was the place the physicians documented labs that were ordered. The physician progress notes did not indicate that any Valproic Acid levels had been ordered or drawn since 8/13/12.

In an interview with the Director of Nursing on 7/25/13 at 1 P.M., she indicated no Valproic Acid levels were done since her admission on 8/23/12. She also indicated there were no labs included in the admission paperwork.

The Medication Regimen Reviews the pharmacy performed monthly were reviewed from 9/10/12 to 7/25/13. There was no documentation for the medication of Depakote or Valproic Acid labs.

3. The Director of Nursing provided the policy titled, "Medication Regiment Review and Reporting" from the pharmacy dated 10/07. The policy indicated, "...The consultant pharmacist reviews the medication regimen of each resident at least

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	monthly. Identification of irregularities may occur by the consultant pharmacist...." 4. The 2010 Nursing Spectrum Drug Handbook indicated on ,"...page 1217...Boxed warning...hepatic failure resulting in death has occurred in patients receiving Depakote...incidence of fatal hepatotoxicity decreases considerably in progressively older patients...page 1219...patient monitoring...Monitor valproic acid blood level...." 3.1-25(i)			